In the Matter of the Arbitration between

Shore Orthopaedic Group a/s/o P.V.
CLAIMANT(s),

v.

Plymouth Rock Assurance of New Jersey
RESPONDENT(s).

Forthright File No: NJ1902001831924
Proceeding Type: In-Person
Insurance Claim File No: 256401462864
Claimant Counsel: Midlige Richter
Claimant Attorney File No: 190.1936
Respondent Counsel: Law Office of Patricia A. Palma
Respondent Attorney File No: 256401462864WAF
Accident Date: 07/25/2016

Award of Dispute Resolution Professional

Dispute Resolution Professional: Sylvia A Hebron Esq.

I, the Dispute Resolution Professional assigned to the above matter, pursuant to the authority granted under the "Automobile Insurance Cost Reduction Act", *N.J.S.A. 39:6A-5, et seq.*, the Administrative Code regulations, *N.J.A.C. 11:3-5 et seq.*, and the *Rules for the Arbitration of No-Fault Disputes in the State of New Jersey* of Forthright, having considered the evidence submitted by the parties, hereby render the following Award:

Hereinafter, the injured person(s) shall be referred to as: PV

In Person Proceeding Information

A proceeding was conducted on: 08/16/2019

Claimant or claimant's counsel appeared in person . Respondent or respondent's counsel appeared in person .

The following amendments and/or stipulations were made by the parties at the hearing:

The amount of the Demand was amended to $227.25 for dates of service 1/14/19 and 3/4/19.

Findings of Fact and Conclusions of Law

In rendering this decision I have reviewed the pre-hearing and post hearing submissions of the parties and I have considered the oral arguments of the parties on 8/16/19. Arguments made outside of the scope of the post hearing request are not considered.

FACTS

PV was involved in an automobile accident on 7/25/16 from which he suffered bodily injuries. Subsequent to the accident, PV sought treatment with claimant and was eventually referred for lumbar decompression with fusion surgery at L4-5 and L5-S1. At the time of the accident he was eligible to receive personal injury protection benefits ("PIP") under a policy of insurance issued by Palisades, respondent herein. Claimant now alleges improper denial of requested surgery as well as office evaluations billed for dates of service 1/14/19 and 3/4/19 and has instituted this action pursuant to a valid Assignment of Benefits.

ISSUES

1) Whether or not requested lumbar surgery is medically necessary and for injury causally related to the subject accident;

2) Whether or not office visits billed for dates of service 1/14/19 and 3/4/19 were medically necessary and for injury causally related to the subject accident.

No other issues were identified by the parties at hearing and no other issues will be addressed herein.

ANALYSIS

Medical Necessity/Causal Relation

Claimant argues, following the subject accident, PV was beset by neck pain radiating to the shoulders and arms, headaches and low back pain radiating to both legs (right greater than left). Claimant indicates these complaints continued despite a course of chiropractic treatment.

Claimant argues PV initially presented to Dr. Glastein on 8/8/16 for the ongoing complaints. Physical examination documented findings which included tenderness and pain of the lumbar spine on extension. Dr. Glastein's assessment was of cervical and lumbar radiculopathy for which continued chiropractic treatment was recommended along with medication management. Claimant indicates PV presented to Dr. Glastein again on 9/12/16 with continued complaints of back pain going to the legs with tingling and numbness. Recommendation was for lumbar MRI.

Claimant argues PV presented to Dr. Glastein for follow up on 11/14/16 at which time physical examination of the lumbar spine noted tenderness, bilateral sciatic notch tenderness and positive straight leg raise test on the right. Recommendation was for a course of epidural blocks. Claimant indicates PV presented to Dr. Woska on 11/16/16, at Dr. Glastein's request. Claimant also indicates Dr. Woska's interpretation of the lumbar MRI indicated large central annular tear at L4-5 associated with herniation and large right extruded disc herniation at L5-S1 impacting the S1 nerve root with bulging at the same

level. Physical examination of the lumbar spine noted pain on extension, positive straight leg raise test on the right, decreased sensation at the right calf. Dr. Woska's assessment was that PV was symptomatic for acute disc herniation. Recommendation was for a series of lumbar epidural steroid injections which were ultimately administered between December 2016 and July 2017. Claimant indicates, after each injection, PV reported approximately 50% improvement followed by recurrence of pain.

Claimant indicates PV returned to Dr. Woska on 10/29/18 at which time he reported he experienced three months of pain relief after the last epidural injection before he returned to baseline pain levels. Physical examination again noted positive straight leg raise on the right as well as dysesthesias in the right lateral leg and pain on flexion, primarily at the right L5-S1 level.

Claimant indicates PV returned to Dr. Glastein on 1/14/19 with complaint of severe back pain radiating to the legs which he reported he could no longer tolerate and which affected his activities of daily living. Claimant argues Dr. Glastein determined PV was a surgical candidate for anterior discectomy and plating at L4-5 and L5-S1 along with posterior decompression and spinal instrumentation at the same levels. Claimant indicates the surgical recommendation was made due to failure of extensive conservative treatment. Claimant indicates PV returned to Dr. Glastein on 3/4/19. Claimant notes respondent denied reimbursement for both dates of service.

Respondent relies upon reviews performed by Dr. Weintraub on 1/23/19 and Dr. Strauchler on 2/14/19 in support of its denial of reimbursement. Dr. Weintraub reviewed the medical record regarding the request for surgery and questioned causation as the request was made 2 ½ years after the subject accident. He noted claimant had not seen PV for more than 1 ½ years and that he had had an "excellent response" to the lumbar epidurals as the last injection was administered on 7/11/17 with a large gap in care through 10/25/18.

Dr. Strauchler felt the 1/14/19 exam noted new symptoms and findings which were related to PV's work activity as the owner/operator of a pizza parlor. He also indicated Dr. Glastein did not document a complete orthopedic or neurological exam and the report did not address the treatment gap or the "markedly different current symptoms and findings".

Importantly, respondent argues PV was involved in a subsequent motor vehicle accident on 6/17/18, which was during the 14 month treatment gap following the last epidural injection and the time PV returned to Dr. Woska on 10/29/18. Respondent notes the subsequent accident resulted in a total loss of the host vehicle which sustained "moderate left side damage". Respondent questions why neither of PV's treating physicians referenced the subsequent accident when PV returned to treatment. Respondent also notes, prior to the subsequent accident, there was no surgical recommendation and PV was responding well to injection therapy. Respondent argues this is a "classic Bowe case" wherein the patient did not tell her treating doctors about a prior motor vehicle accident in which she had been involved.

Claimant argues respondent's invoking of a subsequent accident is a red herring in that respondent failed to present 1) a CIB run showing that PV filed a claim for the accident, 2) a PIP application showing a claim for injuries, 3) treatment records regarding the subsequent accident, 4) a MDR or IME showing that PV sustained injuries in the subsequent accident or 5) a police report showing that PV was injured in the subsequent accident. Claimant questions, if PV was in fact injured in the subsequent accident, why he waited four months thereafter before presenting to Dr. Woska. Claimant maintains PV was not injured in the subsequent accident therefore it was not necessary to mention it to his doctors. Claimant also argues the lumbar MRI was performed only two months after the subject accident and serious objective findings were documented at that time. Claimant argues there was no prior surgical recommendation because he and his doctors had not yet arrived at the point of surgical decision

making.

Pursuant to N.J.S.A. 39:6A-4, PIP benefits are afforded, without regard to negligence, liability or fault of any kind, to the named insured and members in the family residing in the household who sustain bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile, and to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with the permission of the named insured. Legal causation for PIP purposes requires a substantial nexus between the injury and a qualifying automobile. See New Jersey Automobile Insurance Law, 2011 Edition, Craig & Pomeroy, sec. 6:2-3.

Where there is a dispute as to the services provided, the burden rests upon the claimant to establish that the medical expenses for which it seeks PIP benefits were reasonable, necessary and causally related to the automobile accident. See Miltner v. Safeco Ins. Co. of America, 175 N.J. Super. 156 (Law Div. 1980). Pursuant to N.J.S.A. 39:6A-2(e), "medical expenses" means reasonable and necessary expenses for treatment or services as provided by the policy. Additionally, pursuant to N.J.S.A. 39:6A-2(m), "medically necessary" means that the treatment is consistent with the symptoms or diagnosis, and treatment of the injury and is not 1) primarily for the convenience of the injured person or provider and 2) is the most appropriate standard or level of service which is in accordance with standards of good practice and standard professional treatment protocols and 3) does not involve unnecessary diagnostic testing.

Further, the applicable regulations define "medically necessary" or "medical necessity" at N.J.A.C. 11:3-4.2 as the medical treatment or diagnostic test which is consistent with the clinically supported symptoms, diagnosis or indications of the injured person which is 1) the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols and 2) not primarily for the convenience of the injured person or provider and 3) does not include any unnecessary testing or treatment. Finally, "clinically supported" is also explained at N.J.A.C. 11:3-4.2 as a health care provider who has, prior to selecting, performing or ordering the administration of a treatment or diagnostic test 1) personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test and 2) physically examined the patient. . .and 3) considered any and all previously performed tests that relate to the injury and the results and which are relevant to the proposed treatment or test and 4) recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

Bowe v. NJ Manufacturers, 367 N.J. Super 128 (App. Div. 2004) stands for the proposition that a plaintiff seeking PIP benefits must prove, by a preponderance of the evidence, that the treatment for which she seeks reimbursement was proximately caused by the particular automobile accident triggering coverage under her policy. In reviewing the Bowe decision, I note that the Court opined that a carrier may assert as a defense to a PIP claim that the treatment for which the insured is seeking benefits is exclusively related to a pre-existing injury or condition. When this defense is raised, the insured has the burden of proving that the treatment at issue is causally linked to either (1) an aggravation of that injury or condition, or (2) a new injury independent of that pre-existing injury or condition. In either case, the treatment must have resulted from the particular automobile accident triggering coverage.

Pursuant to N.J.A.C. 11:3-4.4(e), [f]ailure to request decision point review or precertification where required or failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested shall result in an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond in accordance with its approved decision point review plan.

N.J.A.C. 11:3-4.7(c)(4) provides that a decision point review plan filing shall include the following information . . . procedures for the prompt review, not to exceed three business days, of decision point review and precertification requests by insureds or providers . . .

After reviewing the medical evidence and the arguments of the parties as well as the standard of medical necessity as outlined above, I find that claimant has proven by a preponderance of the evidence that the treatment at issue is for injury causally related to the subject motor vehicle accident and is medically necessary. The clinical examinations revealed clinically supported symptoms, indications and diagnoses that support the requested treatment including lumbar spine tenderness, positive straight leg raise on the right and sensory dysesthesias. Though Dr. Strauchler indicated claimant's 1/14/19 report of exam "markedly new and different symptoms" than those documented at the time of the initial examination, there is no discussion as to whether or not there was or could have been a progression of the initial symptoms with the passage of time. I note the 8/8/16 report of exam documents lumbar tenderness, pain on extension and positive straight leg raise. By 11/14/16, reported findings on exam included bilateral sciatic notch tenderness and by 11/16/16, there was documented decreased sensation in the posterior right calf and significant paraspinal muscle spasms. Lumbar MRI of 9/26/16 documented interpreted findings of central disc protrusion at L4-5 with annular tear and no canal stenosis or foraminal narrowing as well as posterior and right disc extrusion effacing the lateral recess at L5-S1 and compressing the right S1 nerve root with no canal stenosis and partial narrowing of proximal right neural foramen.

Additionally, I have not been presented with evidence that the subject accident caused any new physical injuries to PV so as to break the causal chain with the subject accident. Further, though claimant did not reference the subsequent accident as part of PV's history, neither did respondent's doctors (both of whom reviewed the medical record after the second accident had occurred) which may be indicative of a lack of personal injuries sustained therein. The police report submitted by respondent for the second accident states "No injuries were reported. Both vehicles driven from the scene". Accordingly, the requested surgery is awarded as well as reimbursement for dates of service 1/14/19 and 3/14/19. As there is no evidence of pre-certification request(s) for the re-evaluations, reimbursement is subject to pre-certification penalties.

CONCLUSION

Claimant is awarded the amount of $113.63 in addition to the performance of the requested surgery. This amount reflects pre-certification penalties and is subject to the NJ fee schedule and applicable co-payments and/or deductibles, if any. **Any issues regarding billing, coding, treatment frequency or other administration of claimant's bills as to the requested lumbar surgery are not the subject of the instant arbitration and shall be addressed at a later date if they should arise.**

Based upon a review of the arguments of the parties and the evidence submitted, I find claimant a successful claimant entitled to attorney's fees. Therefore, attorney's fees are awarded as outlined pursuant to Rule 22 of the New Jersey No-Fault PIP Arbitration Rules, effective April 1, 2011, administered by Forthright and the PIP Alternate Dispute Resolution Rules as amended on May 1, 2017; N.J.S.A. 39:6A-5.2(g) and N.J.A.C. 11-3-5.6(e).

Where attorney's fees for a successful claimant are requested, the DRP shall make the following analysis, consistent with the jurisprudence of this State to determine reasonable attorney's fees and shall address each item below in the award:

1. Calculate the "lodestar", which is the number of hours reasonably

expended by the successful claimant's counsel in the arbitration multiplied by a reasonable hourly rate in accordance with the standards in Rule 1.5 of the Supreme Court's Rules of Professional Conduct.

i. The "lodestar" calculation shall exclude hours not reasonably expended;

ii. If the DRP determines that the hours expended exceed those that competent counsel reasonably would have expended to achieve a comparable result, in the context of the damages prospectively recoverable, the interests vindicated, and the underlying statutory objectives, then the DRP shall reduce the hours expended in the "lodestar" calculation accordingly; and

iii. The "lodestar" total calculation may also be reduced if the claimant has only achieved partial or limited success and the DRP determines that the "lodestar" total calculation is therefore an excessive amount. If the same evidence adduced to support a successful claimant was also offered on an unsuccessful claim, the DRP should consider whether it is nevertheless reasonable to award legal fees for the time expended on the unsuccessful claim.

2. DRPs, in cases when the amount actually recovered is less than the attorney's fee request, shall also analyze whether the attorney's fees are consonant with the amount of the award. This analysis will focus on whether the amount of the attorney's fee request is compatible and/or consistent with the amount of the arbitration award. Additionally, where a request for attorney's fees is grossly disproportionate to the amount of the award, the DRP's review must make a heightened review of the "lodestar" calculation described above.

Pursuant to RPC Rule 1.5(a), a lawyer's fee shall be reasonable. The factors to be considered in determining reasonableness of a fee include the following:

1) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

2) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

3) The fee customarily charged in the locality for similar legal services;

4) The amount involved and the results obtained;

5) The time limitations imposed by the client or by the circumstances;

6) The nature and length of the professional relationship with the client;

7) The experience, reputation, and ability of the lawyer or lawyers performing the services;

8) Whether the fee is fixed or contingent.

I have reviewed claimant counsel's certification of services which requests attorney's fees of $2,665.00 and costs of $228.90. Counsel requests fees based on 8.20 hours of legal work at the rate of $325.00 per hour. Respondent argues that the hourly rate and amount of hours billed are excessive.

In determining the amount of the attorney fee, I have also considered the principles set forth in Enright v. Lubow, 215 N.J. Super. 306 (App. Div.), certif. den. 108 N.J. 193 (1987); Litton Industries v. IMO Industries, 200 N.J. 372 (2009); Scullion v. State Farm Ins. Co., 345 N.J. Super. 431 (App. Div. 2001) and Rendince v. Pantzer, 141 N.J. 292 (1995) in determining the "lodestar" for legal fees as well as determining whether they should be enhanced or reduced. I have also considered respondent's objection to the amount of fees sought. Applying these factors, I find that an attorney's fee of $2,100.00 is consonant with the award. Costs of $228.90 are also awarded.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded

Medical Provider	Amount Claimed	Amount Awarded	Payable To
Shore Orthopaedic Group	$227.25	$113.63	Shore Orthopaedic Group

The awarded amounts are subject to:
Deductibles
Co-payments
Medical fee schedule

2. Income Continuation Benefits	Not in Issue	
3. Essential Services Benefits	Not in Issue	
4. Death Funeral Expense Benefits	Not in Issue	
5. Award of Interest	Awarded	Amount to be calculated by Respondent pursuant to N.J.S.A. 39:6A-5.2g

Attorney's Fees and Costs

I find that the Claimant prevailed and I award the following costs and fees (payable to Claimant's attorney unless otherwise indicated) pursuant to N.J.S.A. 39:6A-5.2g

Cost:$ 228.90 Attorney's fees:$ 2,100.00

THIS AWARD is rendered in full satisfaction of all claims and issues presented in the arbitration proceeding.

Entered in the State of New Jersey

Sylvia A. Hebron

Sylvia Hebron, Esq.
Dispute Resolution Professional

Date:09/30/19